MCKINNEY
PERIODONTICS & IMPLANT DENTISTRY

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr._____
Last First Middle Initial

I wish to be called at: home work other_____ Name of Spouse/Partner_____

Address _____Apt. No. _____

City, State, Zip _____

Home Phone (____)_____Work Phone (___)_____Ext.#_____

Birthdate _____ Social Security # _____-_____-_____

Referred by _____Your General Dentist _____
(If Different from Referral)

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of Insured_____

Relationship to Patient_____

Insured's Birthdate _____

Soc. Sec. # _____-_____-_____

Insurance ID # _____

Employer_____

Insurance Co. _____

Insurance Address _____

_____

Group # _____

Group Name _____

___I am not covered by any Dental Insurance at this time

I hereby authorize David T Philofsky, DDS, MS, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to David T Philofsky, DDS, MS of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by David T Philofsky, DDS, MS.

Privacy of Information Policy: I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Cancellation Policy: There will be a substantial charge if a surgical treatment appointment is canceled with less than 3 working days notice. All other appointments require 1 full working day's notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

Payment: We request that all balances be paid in full within 90 days of treatment, unless specific financial arrangements are made before treatment. I acknowledge that I have read and understand the above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient or Patient's Legal Guardian Date of Signature

MCKINNEY
PERIODONTICS &
IMPLANT DENTISTRY

DENTAL QUESTIONNAIRE FOR NEW PATIENT

YOUR DENTIST'S NAME _____ FOR HOW LONG:_____

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 5 YEARS:

❑LESS THAN ONCE A YEAR ❑ONCE A YEAR ❑TWICE A YEAR ❑THREE TIMES A YEAR ❑FOUR TIMES A YEAR

MO/YEAR OF YOUR LAST DENTAL EXAM_____ MO/YEAR OF YOUR LAST DENTAL X-RAYS_____

ARE YOU PRESENTLY SATISFIED WITH THE CONDITION OF YOUR MOUTH AND TEETH(CIRCLE ONE):

❑VERY SATISFIED ❑SATISFIED ❑IT'S O.K. ❑SOMEWHAT DISSATISFIED ❑VERY DISSATISFIED

YES NO

❑ ❑ DO YOU PRESENTLY HAVE ANY PAIN, DISCOMFORT OR IMPAIRED FUNCTION RELATED TO YOUR MOUTH?
IF YES, PLEASE DESCRIBE? _____

❑ ❑ ARE YOU CURRENTLY AWARE OF ANY INFECTION IN YOUR MOUTH?
IF YES, PLEASE DESCRIBE: _____

❑ ❑ ARE YOU CURRENTLY TAKING ANY ANTIBIOITICS FOR INFECTION? IF SO, WHAT: _____

❑ ❑ DO YOUR GUMS EVER BLEED? IF SO, WHEN: _____

❑ ❑ DO YOU HAVE A PROBLEM WITH BAD BREATH OR HAVE ANY FRIENDS OR FAMILY MADE YOU AWARE OF THIS?

❑ ❑ ARE YOU INTERESTED IN REPLACING LOST TEETH?

❑ ❑ DO YOU EVER HAVE ACHES OR PAINS IN YOUR JAW JOINTS, EARS, FACE, NECK OR HEAD?

❑ ❑ ARE ANY OF YOUR TEETH TENDER WHEN YOU CHEW HARD FOODS?

❑ ❑ ARE ANY OF YOUR TEETH MORE SENSITIVE TO: COLD, HOT, SWEETS, CERTAIN FOODS OR DRINKS?

❑ ❑ ARE ANY PARTICULAR TEETH VERY SENSITIVE OR PAINFUL? WHEN? _____

❑ ❑ ARE YOU CONCERNED ABOUT GUM RECESSION AROUND ANY OF YOUR TEETH?

❑ ❑ ARE YOU CONCERNED ABOUT THE APPEARANCE OF YOUR TEETH OR MOUTH?

❑ ❑ HAVE YOU EVER HAD ORTHODONTIC TREATMENT? ❑WITH BRACES ❑WITH REMOVABLE APPLIANCES
WHEN DID YOU GO THROUGH ORTHODONTIC CARE? _____

❑ ❑ HAVE YOU EVER RECEIVED PERIODONTAL TREATMENT? ❑SCALING/ROOT PLANING ❑GUM SURGERY
WHEN DID YOU GO THROUGH PERIODONTAL CARE? _____

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOU OR MAKES DENTAL TREATMENT EASIER FOR YOU:

❑ I TOLERATE MOST DENTAL CARE REASONABLY WELL AND USUALLY REQUIRE MINIMAL USE OF ANESTHESIA
❑ I APPRECIATE THE USE OF LOCAL ANESTHETIC – IT ALLOWS ME TO TOLERATE MOST DENTAL CARE REASONABLY WELL
❑ I TOLERATE SHOTS IN MY MOUTH WHEN THEY ARE GIVEN WELL
❑ I LIKE THE BENEFITS OF NITROUS OXIDE (LAUGHING GAS)
❑ I PREFER TO BE SEDATED FOR ANY SURGICAL TREATMENT
❑ I PREFER TO BE SEDATED FOR ANY LENGTHY SURGICAL CARE
❑ I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR FOR MORE THAN AN HOUR
❑ I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR VERY LONG DUE TO A NECK, BACK, SPINE PROBLEM
❑ I HAVE DIFFICULTY WHEN TILTED BACK IN THE DENTAL CHAIR (DIZZINESS, BREATHING DIFFICULTY, _____

WHAT ARE YOUR GOALS OR PRIORITIES FOR THE HEALTH, FUNCTION AND APPEARANCE OF YOUR TEETH & MOUTH:
(RATE EACH ITEM FROM 1TO 5 WITH 1 BEING YOUR LOWEST PRIORITY AND 5 YOUR HIGHEST – YOU CAN USE ANY NUMBER MORE THAN ONCE)

____BE ABLE TO CHEW FOOD AND EAT WHAT I ENJOY
____PRESERVE MY TEETH & AVOID DENTURES
____BE FREE OF INFECTION
____BE FREE OF MOUTH PAIN & TENDERNESS
____AVOID REMOVABLE BRIDGEWORK
____FOR MY MOUTH TO LOOK NICE WHEN I SMILE
____MAKE MY TEETH LOOK GOOD
____HAVE A HEALTHY AND HASSLE-FREE MOUTH

_____ _____ _____
Signature of patient or legal guardian Date Reviewed by

MCKINNEY
PERIODONTICS & IMPLANT DENTISTRY

HEALTH QUESTIONNAIRE FOR NEW PATIENT

PHYSICIAN_____ YOUR HMO I.D. # _____

ADDRESS _____ CITY _____ PHONE _____

YOUR AGE _____ HEIGHT_____WEIGHT _____ MO/YEAR OF YOUR LAST MEDICAL EXAMINATION _____

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH (CIRCLE ONE): EXCELLENT GOOD FAIR POOR DON'T KNOW

YES	NO	???	
❑	❑	❑	HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?
			IF YES, PLEASE DESCRIBE _____
❑	❑	❑	HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION DURING THE PAST FIVE YEARS?
			IF YES, PLEASE DESCRIBE _____
❑	❑	❑	ARE YOU TAKING ANY OVER THE COUNTER OR PRESCRIPTION MEDICATIONS AT THIS TIME?
			IF YES, PLEASE LIST: _____
❑	❑	❑	HAVE YOU EVER • RECEIVED I.V., OR • TAKEN ORALLY: AREDIA, ZOMETA , FOSAMAX OR ANY OTHER BISPHOSPHONATES ?
❑	❑	❑	HAVE YOU EVER TAKEN PONDIMIN (FENDLURAMINE) , PHEN-FEN (PHENTERMINE) OR REDUX (DEXPHENFLURAMINE) FOR WEIGHT REDUCTION?
❑	❑	❑	DO YOU REQUIRE PRE-MEDICATION FOR DENTAL TREATMENT DUE TO ARTIFICIAL JOINTS OR HEART?
❑	❑	❑	ARE YOU ALLERGIC TO ANY MEDICATIONS OR LATEX?
			IF YES, PLEASE LIST _____
❑	❑	❑	HAVE YOU EVER HAD ADVERSE REACTION TO ANY DRUGS AND OR ANESETHETICS
			IF YES, PLEASE LIST _____
❑	❑	❑	HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT?
❑	❑	❑	HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, SYSTEMIC LUPUS, ARC OR AIDS?
❑	❑	❑	IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?
❑	❑	❑	ARE YOU REQUIRED, DUE TO HEALTH, TO RESTRICT YOUR WORK OR ACTIVITY IN ANY WAY?
❑	❑	❑	ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND?_____
❑	❑		DO YOU USE ANY KIND OF TOBACCO? IF SO HOW MUCH: _____PER DAY, WEEK, MONTH
❑	❑		DO YOU USE ANY KIND OF ALCOHOL? IF SO HOW MUCH: _____PER DAY, WEEK, MONTH
❑	❑	❑	DO YOU HAVE ANY HISTORY OF SUBSTANCE ABUSE OR DO YOU CURRENTLY USE RECREATIONAL DRUGS?

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE: ❑ **I AM PREGNANT** ❑ **I AM NURSING** ❑ **I AM TAKING BIRTH CONTROL PILLS**

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

❑CHEST PAIN UPON EXERTION	❑RECEIVED BLOODTRANSFUSION	❑SLEEP APNEA	❑HEADACHES
❑SHORTNESS OF BREATH	❑IMPAIRED LIVER FUNCTION	❑ASTHMA	❑MIGRAINES
❑HIGH BLOOD PRESSURE	❑KIDNEY DISEASE	❑BRONCHITIS	❑EPILEPSY
❑LOW BLOOD PRESSURE	❑IMPAIRED KIDNEY FUNCTION	❑EMPHYSEMA	❑SEIZURES
❑HEART VALVE PROSTHESIS	❑ESOPHYGEAL REFLUX	❑SINUS TROUBLES	❑MENTAL HEALTH PROBLEMS
❑MITRAL VALVE PROLAPSE	❑HIATAL HERNIA	❑PERSISTENT COUGH	
❑CONGENITAL HEART LESION	❑G.I. ULCERS	❑TUBERCULOSIS	❑GLAUCOMA
❑RHEUMATIC FEVER	❑ANOREXIA OR BULEMIA		❑WEAR CONTACT LENSES
❑HEART MURMUR	❑IRRITABLE BOWEL SYNDROME	❑JOINT REPLACEMENT SURGERY	❑SEVERELY IMPAIRED VISION
❑DAMAGED HEART VALUE	❑ COLITIS	❑ARTHRITIS	
❑HEART ARRTHYMIIA	❑ DIABETES	❑CONNECTIVE TISSUE DISORDER	❑RECURRENT INFECTIONS
❑TACHYCARDIA		❑OSTEOPOROSIS	❑CHRONIC FATIGUE
❑HEART SURGERY	❑RADIATION THERAPY		❑RECENT WEIGHT LOSS
❑CARDIAC PACEMAKER	❑CHEMOTHERAPY	❑NEUROLOGICAL DISORDERS	
❑HEPATITIS OR JAUNDICE	❑HISTORY OF CANCER	❑STROKE	

Do you have any disease, problem or condition not listed above? Please explain: _____

_____ _____ _____

Signature of patient or legal guardian Date Reviewed by